MITCHELL E. DANIELS, Jr., Governor
STATE OF INDIANA
DEPARTMENT OF HOMELAND SECURITY JOSEPH E. WAINSCOTT JR., EXECUTIVE DIRECTOR

Leadership for a Safe and Secure Indiana

Indiana Department of Homeland Security
EMS Certification, Room E-239
Indiana Government Center South
302 West Washington Street
Indianapolis, IN 46204
1-800-666-7784

STATE OF INDIANA
EMT-INTERMEDIATE CONTINUING EDUCATION REPORT

Public Safety ID Number	**Indiana Public Safety ID Affiliation**	
Last Name	First Name	Middle Initial
Mailing Address 1		
Address 2		
City	State	Zip Code
Driver's License Number	Home Telephone ( )	
Email	Cell Number ( )	

VIOLATION STATEMENT

YES ☐ **NO** ☐ **Have you ever been convicted of a crime other than a minor traffic violation?**

YES ☐ **NO** ☐ **Have you reported this conviction previously?**

If you answer "yes," you must attach official documentation that fully describes the Offense, current status and disposition of the case.

EMS MEDICAL DIRECTOR SIGNATURE

As the Emergency Medical Director, I do hereby affix my signature attesting to the continued competency in all skills outlined in Section III of this document.

Signature of Physician	Date	
Name of Physician (printed)	License Number	State
Telephone of Physician ( )		

EMS REGISTRANT SIGNATURE

I, the undersigned EMT-Intermediate, hereby affirm, under the penalty of perjury, that all statements on this continuing education report are true and correct, including copies of cards, certificates and other required documents for verification. I understand that false statements or documents maybe sufficient cause for revocation by the Indiana Department of Homeland Security and the Emergency Medical Services Commission. I also understand that the audit of the recertification activities listed at any time.

Applicant's Signature	Date

Have you been trained in NIMS/ICS? YES ☐ NO ☐

Level of NIMS/ICS training. 100 ☐ 200 ☐ 300 ☐ 400 ☐ 700 ☐ 800 ☐ Other _____

Would you be willing to assist in a disaster? Yes ☐ NO ☐

INDICATE ALL CURRENT AFFLIATIONS

Ambulance Provider Organizations		
Name of Provider		**Provider Certification Number**
Street Address		City
State	Zip Code	Telephone ( )
Signature of CEO		Date
Name of Provider		**Provider Certification Number**
Street Address		City
State	Zip Code	Telephone ( )

SUPERVISING HOSPITAL

Name of Hospital		
Street Address		City
State	Zip Code	Telephone **( )**
Signature of EMS Coordinator		Date
Name of Hospital		
Street Address		City
State	Zip Code	Telephone **( )**
Signature of EMS Coordinator		Date

Section 1A	
1.	If a formal EMT-Intermediate Refresher course was completed, please attach a copy of the certificate of completion.
2.	If a formal EMT-Intermediate Refresher course was not completed, Section 1A must be completed in its entirety. All signatures must be original.
3.	All in-services and refresher courses must be done at or approved by your Supervising Hospital.

Division I-Preparatory			**Required Five (5) Hours**
Date	**Number of Hours**	**Topic**	**Instructor's Signature**

Division II-Airway			**Required Five (5) Hours**
Date	**Number of Hours**	**Topic**	**Instructor's Signature**
Division III-Medical			**Required Twelve (12) Hours**
Date	**Number of Hours**	**Topic**	**Instructor's Signature**
Division IV-Trauma			**Required Eight (8) Hours**
Date	**Number of Hours**	**Topic**	**Instructor's Signature**

Division V-Special Considerations (Infants, Geriatrics, OB/GYN)			**Required Four (4) Hours**
Date	**Number of Hours**	**Topic**	**Instructor's Signature**
Division VI-Operations (Incident Command, Rescue, Hazmat, Crime Scene,			**Required Two (2) Hours**

Ambulance Operation)			
Date	**Number of Hours**	**Topic**	**Instructor's Signature**
Section 1B: CPR Certification			**Section 1C: ACLS Certification**
Attach a current front copy Of provider card or certification			**Attach a current front copy Of provider card or certification**
CPR and ACLS certification hours may be added to the appropriate divisions in Section 1A.			
Section 2			
Thirty-six (36) Additional Hours of Continuing Education			
1.	**Twelve (12) Hours must be obtained as AUDIT & REVIEW.**		
2.	**No More than Eighteen (18) Hours in any one (1) topic.**		
Date	**Number of Hours**	**Topic**	**Instructor's Signature**

1.	**No Specific amount of time must be spent on each skill or combination thereof.**
2.	**All skills must be directly observed by the EMS Medical Director or EMS educational staff of the Supervising Hospital, either at an in-service or in an actual clinical setting.**
3.	**All Signatures must be original.**

Section 3

Intermediate Skill Maintenance

Patient Assessment/Management

Date	Number of Hours	Topic	Instructor's Signature

Ventilator Management

Date	Number of Hours	Topic	Instructor's Signature

Cardiac Arrest Management

Date	Number of Hours	Topic	Instructor's Signature

Bandaging and Splinting

Date	Number of Hours	Topic	Instructor's Signature

IV Therapy and IO Therapy

Date	Number of Hours	Topic	Instructor's Signature

Spinal Immobilization

Date	Number of Hours	Topic	Instructor's Signature

OB/Gynecological Skills

Date	Number of Hours	Topic	Instructor's Signature
Communications/ Documentation			
Date	**Number of Hours**	**Topic**	**Instructor's Signature**

1.	**No Specific amount of time must be spent on each skill or combination thereof.**
2.	**All skills must be directly observed by the EMS Medical Director or EMS educational staff of the Supervising Hospital, either at an in-service or in an actual clinical setting.**
3.	**All Signatures must be original.**